Agency Name  Managed Risk Medical Insurance Board  Date Stamp  Date Stamp  Date Stamp  Date Stamp  Date Stamp  For Official Use Only  Benefits and Quality Monitoring Division  Street Address  1000 G Street, Suite 450  Area Codu/Phone Number  John Street Address  John Street Address  Date of Original Filling:  Individual  Last Name  Last Name  Last Name  First Name  Donor Name and Address  City  State  Do Charact Replace Association - RHC  Addissas  The CHA Rural Health Care Center (RHC) advocates for the needs and interests of rural hospitals.  If applicable, identify the name of each source and the amount(s) solicited or received by the donor for this gift:  Name  Name  Amount  Name  Name  Amount Information  Date and Amount of Payment (other their trave)  Date and Amount of Payment Information (round to whole dollars)  Travel Payment Information (round to whole dollars)  Location of Travel  Last Name  Sarah  Location of Travel  Last Name  Sarah  Staff Services Manager   MRMIB, Benefits  Last Name  First Name  First Name  Sarah  Staff Services Manager   MRMIB, Benefits  Last Name  First Name  Tillie  Department/Orision  Payment (Use this spice or an attentment for any additional information.)	Julio Agency Report	A Public I	Document	医水溶肿 化二羟醇羟基基	
Managed Nisk Medical Insurance Board   Division, Department, or Region (if applicable)	. Agency Name			7	California
Division, Department, or Region (if applicable) Benefits and Quality Monitoring Division Street Address  1000 G Street, Suite 450 Area Code/Phone Number   E-mail   drushton@mrmib.ca.gov   Date of Original Filing:   (monih. day, year)   Diana Rushton, Filing Officer  Donor Name and Address   1001   Galifornia Hospital Association - RHC	Managed Risk Medical Insu	ırance Board	,		
Benefits and Quality Monitoring Division  Street Address  Area Code/Phone Number   E-mail   drushton@mrmib.ca.gov   Date of Original Filing:   (monih, day, year)   Date of Original Filing:   (Monih of Original Filing:	Division, Department, or Reg	ion (if applicable)	:		
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Agency Contact (name and title)   Date of Original Filling:     Date of Original Filling:     Date of Original Filling:       Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:     Date of Original Filling:   Date of Original F		E-mail	w <u> </u>		
Agency Contact (name and title) Diana Rushton, Filing Officer  Donor Name and Address Individual Last Name Plat Name Scaramento CA 95814  Address City Stato CP Other California Hospital Association - RHC Name Name CA 95814  Address City Stato CP Other CHA Rural Health Care Center (RHC) advocates for the needs and interests of rural hospitals.  If applicable, identify the name of each source and the amount(s) solicited or received by the donor for this gift:  Name Amount	916 327-8011			Amendment (explain in comment section)	
Diana Rushton, Filling Officer    Donor Name and Address	Agency Contact (name and title)	arderitering minib.ca.gov		Date of Original Filing:	
Individual	·			(month, day, year)	
1215 K Street, Ste 800   Sacramento   CA   95814					
Last Name  First Name  Sacramento  CA  95814  Address  City  State  Zip Code  The CHA Rural Health Care Center (RHC) advocates for the needs and interests of rural hospitals.  The CHA Rural Health Care Center (RHC) advocates for the needs and interests of rural hospitals.  If applicable, identify the name of each source and the amount(s) solicited or received by the donor for this gift:  Name  Amount  Name  Name  Name  Amount  Name	☐ Individual		☑ Othor	California Hospital Ass	sociation - RHC
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